

THE RESULTS OF THE FEDERAL INVESTIGATION

NORTH CAROLINA DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM

During the federal investigation, several senior executives from a number of hospitals, more than fifteen former and current State officials (primarily employees of the Division of Medical Assistance (“DMA”)), an outside contracting agency, and the attorney representing the largest beneficiary hospitals cooperated fully and completely with the investigation. They consented to being interviewed and provided thousands of documents, including numerous pages of internal emails, which provided a literal paper trail of the operation of the North Carolina DSH program.

The three U.S. Attorneys for North Carolina seek to explain the findings of the federal investigation, identify the causes of the substantial overpayments made to the State of North Carolina (“State”) and the hospitals, and dispel any public perception that any of the individuals, hospitals, or other entities identified in the Report by the Office of the State Auditor on March 13, 2004 (“Report”) engaged in intentional wrongdoing.

From 1997 through 2003, the State of North Carolina disbursed approximately \$1.2 billion in DSH payments, of which nearly seventy percent were reimbursements from the federal government. The Report raised concerns that as much as \$400 million in those federal funds had been misappropriated by the State and the hospitals to which those funds were distributed. In particular, the Report alleged that the funds were distributed to ineligible organizations.

The federal investigation found that substantial overpayments of federal funds were made to both the State and certain hospitals. However, the federal investigation uncovered no evidence that funds had been siphoned off to unauthorized recipients.

The federal investigation also found that although the manner in which the disbursements

from the State to the hospitals was unusual, in that the hospitals relied on the use of escrow accounts as an intermediary step, the funds were ultimately distributed to the beneficiary hospitals as intended under the program. The federal investigation further found that the use of escrow accounts was directly related to the State's use of an inter-governmental transfer (IGT) program which was designed to maximize the federal share of Medicaid costs.

The investigation confirmed that certain data errors were made by the State's outside contractor responsible for computing reimbursement rates on the amount of payments. DMA became aware of the errors shortly after they occurred, however, no evidence was found that the hospitals had knowledge of the extent of the errors until after the issuance of the Report. Although the errors did result in overpayments, the federal investigation did not conclude that either DMA or any hospital knowingly used the effect of those errors intentionally to obtain excess reimbursements.

The federal investigation examined the failure of the State to engage in annual cost settlements, which may have substantially reduced the amount of overpayments. The State argued that its ability to engage in cost settlements was attributable to a number of factors, including changes in the methodology for submitting cost reports, the lack of clear statutory and regulatory guidance on the manner of making certain critical calculations, and substitutions of the entities charged with handling cost report reviews and settlements. While none of these factors alone, or in combination, adequately explain the State's failure to insist on annual cost settlements, the investigation did not reveal that the delay in the cost settlement process was designed to conceal the overpayments made to individual hospitals or that any State official benefitted personally from this delay. DMA has now taken appropriate steps to prevent a recurrence of these problems.

The federal investigation examined whether the state had improperly ceded control of the

DSH reimbursement program to a group of beneficiary hospitals and its legal counsel. The federal investigation gave special scrutiny to this concern to determine whether there was any malfeasance or misfeasance by State officials, and whether any of the beneficiary hospitals or their legal counsel had improperly benefitted from the arrangement. Based on the evidence reviewed, this allegation was not substantiated.

The federal investigation determined that hospital involvement with the administration of the program came about primarily because the State agency tasked with the responsibility for the program was understaffed and lacked sufficient expertise or equipment to carry out the responsibilities for maintaining and monitoring such a complex program. Rather than permit federal dollars earmarked for health care for the poor to go unclaimed, a collaborative effort among the State's public and private hospitals, and the North Carolina Hospital Association, in cooperation with, or acquiescence by, State officials, launched the Medicaid Reimbursement Initiative which was designed to obtain maximum federal contributions to State Medicaid funding.

Most of the cost data used to determine the amount of State Medicaid reimbursements was gathered and calculated by the hospitals. Primary responsibility for maintaining the initiative was vested in a small group of large hospitals, who received the lion's share of reimbursements. The responsibility for performing the annual calculations for reimbursement amounts was vested in Carolinas Medical Center (CMC). CMC and most of the other hospitals were represented by the same attorney who had regular and personal contact with DMA officials responsible for administering the reimbursement program. CMC initiated the project and its employees were primarily responsible for many aspects of the initiative. CMC was also the largest beneficiary of the reimbursement program. These facts gave rise to an appearance of conflicts of interest.

The federal investigation has shown, however, that CMC did not operate in a vacuum. Other hospitals participated in various aspects of the initiative and all of the data and methodologies used to generate the reimbursements were freely shared among the hospitals eligible for reimbursement. The federal investigation has shown that no hospital improperly benefitted to the detriment of any other hospital.

The federal investigation determined that the reimbursements made were appropriately tied to the number of patients served by the hospitals and the costs associated with the care given. The investigation did not reveal that legal counsel for CMC and other hospitals received fees tied to the amount of reimbursements received from the State or that the administrative costs charged by CMC were improper. Nor did the federal investigation find that the law firm which represented the largest beneficiary hospitals received excessive fees for the services performed.

In conclusion, the federal investigation did not uncover any evidence of payments or any other tangible benefit to any State official for allowing the hospitals to operate the DSH program. The investigation did not find that there was misappropriation of funds, kickbacks, graft, *quid pro quo* dealings, or public corruption. Nevertheless, the federal investigation determined that because of numerous errors (including DMA's failure to settle cost reports in a timely manner) overpayments to the State and to hospitals throughout North Carolina have occurred. The State and the federal government have agreed that \$151.5 million represents the best estimate of the total amount of overpayments, and the State has agreed to fully repay this amount under the terms of the Settlement Agreement.